

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0011650</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>GOOD SAMARITAN CARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2299 METROPOLIS STREET</u> <u>METROPOLIS</u> <u>62960-1393</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>MASSAC</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>BARBARA WATERS</u> (Title) <u>ADMINISTRATOR</u>	
Telephone Number: <u>(618) 524-2634</u> Fax # <u>(618) 524-2507</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>MICHAEL W. GIVENS, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>GRAY HUNTER STENN LLP</u> <u>P O BOX 1728, MARION, ILLINOIS 62959</u> (Telephone) <u>(618) 993-2647</u> Fax # <u>(618) 993-3981</u>	
IDPA ID Number: <u>37-0859225002</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>01/01/65</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Trust		<input type="checkbox"/> Individual	
IRS Exemption Code <u>501 (c) (3)</u>		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>MICHAEL W. GIVENS, CPA</u> Telephone Number: <u>(618) 993-2647</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GOOD SAMARITAN CARE CENTER# 0011650 Report Period Beginning: 01/01/2001 Ending: 12/31/2001**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,811</u>	<u>413</u>	<u>2,188</u>	<u>4,412</u>	8
9	SNF/PED					9
10	ICF	<u>17,165</u>	<u>5,817</u>		<u>22,982</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,976</u>	<u>6,230</u>	<u>2,188</u>	<u>27,394</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.84%

D. How many bed-hold days during this year were paid by Public Aid?

134 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)MEALS ON WHEELS, OUTPATIENT THERAPYF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/65

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 27 and days of care provided 2,188Medicare Intermediary ADMINASTAR FEDERAL - KENTUCKY**IV. ACCOUNTING BASIS**ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number GOOD SAMARITAN CARE CENTER

0011650

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	148,329	11,951	6,095	166,375		166,375		166,375		1
2	Food Purchase		116,868		116,868		116,868	(8,183)	108,685		2
3	Housekeeping	47,276	9,823		57,099		57,099		57,099		3
4	Laundry	38,291	7,994		46,285		46,285		46,285		4
5	Heat and Other Utilities			61,506	61,506		61,506		61,506		5
6	Maintenance	44,663	2,086	59,989	106,738		106,738		106,738		6
7	Other (specify):*										7
8	TOTAL General Services	278,559	148,722	127,590	554,871		554,871	(8,183)	546,688		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	826,457	38,698	88,145	953,300		953,300		953,300		10
10a	Therapy	29,462	4,009	214,885	248,356		248,356		248,356		10a
11	Activities	26,336	3,554	8,137	38,027		38,027		38,027		11
12	Social Services	48,731	584	1,440	50,755		50,755		50,755		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	930,986	46,845	312,607	1,290,438		1,290,438		1,290,438		16
	C. General Administration										
17	Administrative	63,405		140,437	203,842		203,842		203,842		17
18	Directors Fees										18
19	Professional Services			26,459	26,459		26,459	(13,917)	12,542		19
20	Dues, Fees, Subscriptions & Promotions			31,424	31,424		31,424	(14,513)	16,911		20
21	Clerical & General Office Expenses	60,053	7,774	34,563	102,390		102,390		102,390		21
22	Employee Benefits & Payroll Taxes			271,521	271,521		271,521		271,521		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,588	5,588		5,588		5,588		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			59,906	59,906		59,906		59,906		26
27	Other (specify):*	48,414		6,925	55,339		55,339		55,339		27
28	TOTAL General Administration	171,872	7,774	576,823	756,469		756,469	(28,430)	728,039		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,381,417	203,341	1,017,020	2,601,778		2,601,778	(36,613)	2,565,165		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

GOOD SAMARITAN CARE CENTER

#0011650

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			178,687	178,687		178,687	(31,186)	147,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,644	2,644		2,644	(1,756)	888			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			7,975	7,975		7,975		7,975			34
35	Rent-Equipment & Vehicles			16,341	16,341		16,341		16,341			35
36	Other (specify):*											36
37	TOTAL Ownership			205,647	205,647		205,647	(32,942)	172,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,257	4,698	47,955		47,955		47,955			39
40	Barber and Beauty Shops			6,290	6,290		6,290		6,290			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):* Resd Rel Admin			505	505		505		505			43
44	TOTAL Special Cost Centers		43,257	62,958	106,215		106,215		106,215			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,381,417	246,598	1,285,625	2,913,640		2,913,640	(69,555)	2,844,085			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GOOD SAMARITAN CARE CENTER

0011650

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,183)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(31,186)	V-30		9
10	Interest and Other Investment Income	(1,756)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,917)	V-19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(12,477)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,036)	V-20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,555)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (69,555)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		6,290	V-40	41
42	Laboratory and Radiology	X		2,628	V-39	42
43	Prescription Drugs	X		45,327	V-39	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 54,245		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
GOOD SAMARITAN CARE CENTER

Page 5A

ID# 0011650
Report Period Beginning: 01/01/2001
Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

0011650

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
American Lutheran Welfare Society	100%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Land Rental	\$ 7,975	Member of the Board of Directors	0.00%	\$ 7,975	\$ *	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 7,975			\$ 7,975	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GOOD SAMARITAN CARE CENTER # 0011650 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GOOD SAMARITAN CARE CENTER # 0011650 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	National State Bank		X	Mortgage	Interest Only	3/09/1994	\$ 380,000	\$ 298,752		6.2500	\$ 62	1							
2	National State Bank		X	Construction	Interest Only	9/12/1996	1,900,000	1,673,525		6.2500	348	2							
3	National State Bank		X	Construction Equipment	Interest Only	9/01/1996	262,000	260,047		6.2500	54	3							
4	National State Bank		X	Corrective Construction	Interest Only	3/01/1999	550,000	469,733		6.2500	98	4							
5												5							
	Working Capital																		
6	National State Bank		X	Working Capital	Interest Only	6/09/1995	100,000	99,732	yearly	6.2500	20	6							
7	National State Bank		X	Working Capital	Interest Only	3/01/1998	350,000	348,735	yearly	6.2500	72	7							
8	City of Metropolis		X	Working Capital	\$1,478.70	9/20/2001	400,000	397,555	15 years	2.0000	1,990	8							
9	TOTAL Facility Related					\$1,478.70		\$ 3,942,000	\$ 3,548,079			\$ 2,644	9						
	B. Non-Facility Related*																		
10												10							
11	NOTE: INTEREST ON HOLD DURING FORBEARANCE PERIOD.											11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$	14						
15	TOTALS (line 9+line14)							\$ 3,942,000	\$ 3,548,079			\$ 2,644	15						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **GOOD SAMARITAN CARE CENTER**# **0011650** Report Period Beginning: **01/01/2001** Ending: **12/31/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	99	8	
	1997	42	9	
	1998	47	10	
	1999	50	11	
	2000	N/A	12	
				FOR OHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAMARITAN CARE CENTER COUNTY MASSAC

FACILITY IDPH LICENSE NUMBER 0011650

CONTACT PERSON REGARDING THIS REPORT Glenda Frazine

TELEPHONE (618) 524-2634 FAX #: (618) 524-2507

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 42,793

B. General Construction Type:
 Exterior
 Brick
 Frame
 Brick, Block & Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	50	1965	1965	\$ 359,848	\$ 8,996	40	\$ 8,996	\$	\$ 332,852
5	35	1974	1974	312,514	7,812	40	7,812		218,736
6	9	1999	1999	2,463,958	126,391	30	82,132	(44,259)	164,264
7									
8									
Improvement Type**									
9	Building & Land Improvements	1979		10,334		various			10,334
10		1981		15,080	213		213		11,909
11		1982		43,823	1,662		1,662		42,978
12		1983		11,019					11,019
13		1984		46,462	284		284		45,922
14		1985		27,731	1,317		1,317		23,628
15		1986		7,415					7,415
16		1987		10,676	406		406		9,739
17		1988		8,822					8,822
18		1989		4,057	194		194		4,057
19		1990		13,903	1,127		1,127		13,019
20		1991		15,453	615		615		15,453
21		1992		5,234	523	10	523		5,115
22		1993		9,930	993	10	993		8,288
23		1994		10,981	1,263		1,263		9,760
24	Circulating Pump	1996		2,470	247	10	247		1,424
25	Curtains/Mini Blinds	1996		2,945	295	10	295		1,701
26	Bell & Gossett Pump	1997		3,224	393		393		1,965
27	Carpet & Painting	1997		1,250	83	15	83		166
28	300 Hall Heating Units and Chiller	1997		2,555	170	15	170		340
29	Repair Washer	1997		726	48	15	48		96
30	Carpet	1998		418	28	15	28		56
31	Door Alarms	1998		4,000	267	15	267		534
32	Building Improvements	1998		7,131	475	15	475		950
33	New Fence	1999		520	35	15	35		70
34	Air Conditioning Unit	1999		3,085	206	15	206		412
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

01/01/2001 Ending: 12/31/2001

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 209,131	\$ 7,840	\$ 20,913	\$ 13,073	10	\$ 176,732	71
72	Current Year Purchases	13,440	1,344	1,344		10	1,344	72
73	Fully Depreciated Assets	119,415					119,415	73
74								74
75	TOTALS	\$ 341,986	\$ 9,184	\$ 22,257	\$ 13,073		\$ 297,491	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1987 Ford Van	1995	\$ 5,600	\$	\$	\$	3	\$ 5,600	76
77	Patient Transportation	Wheelchair Lift	1995	4,684				5	4,684	77
78										78
79										79
80	TOTALS			\$ 10,284	\$	\$	\$		\$ 10,284	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,060,914	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,687	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,501	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,186)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,284,356	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Barber & Beauty Equipment	\$ 3,440	\$	\$ 3,440	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,440	\$	\$ 3,440	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **16,341** Description: **See Attachment**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2002 \$ _____

13. 2003 \$ _____

14. 2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

Recruit aides from classes taught by Shawnee College & Regional Adult Educational.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,281	\$ 72,770	\$	2,281	\$ 72,770	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		826	38,326		826	38,326	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,078	103,789		3,078	103,789	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts		48	2,068		48	2,068	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$	6,233	\$ 216,953	\$	6,233	\$ 216,953	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 51,033	\$	1
2	Cash-Patient Deposits	3,308		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 183,670)	814,190		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,152		6
7	Other Prepaid Expenses	2,043		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 885,726	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,683,424		14
15	Leasehold Improvements, at Historical Cost	25,220		15
16	Equipment, at Historical Cost	352,270		16
17	Accumulated Depreciation (book methods)	(1,245,630)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,341		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intergenerational Program</u>	13,303		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,838,928	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,724,654	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 605,786	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,308		28
29	Short-Term Notes Payable	99,732		29
30	Accrued Salaries Payable	130,425		30
31	Accrued Taxes Payable (excluding real estate taxes)	(7,170)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 832,081	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,149,595		39
40	Mortgage Payable	298,752		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Restricted Gifts</u>	95,931		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,544,278	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,376,359	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (651,705)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,724,654	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (689,252)	1
2	Restatements (describe):		2
3	Adjustment to Accounts Receivable Allowance Account	100,000	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (589,252)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,453)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (62,453)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (651,705)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,155,943	1
2	Discounts and Allowances for all Levels	(997,607)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,158,336	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	537,048	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 537,048	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,611	12
13	Barber and Beauty Care	6,290	13
14	Non-Patient Meals	6,572	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	64,536	19
20	Radiology and X-Ray	407	20
21	Other Medical Services	2,803	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 149,670	23
D. Non-Operating Revenue			
24	Contributions	4,377	24
25	Interest and Other Investment Income***	1,756	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,133	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,851,187	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	554,871	31
32	Health Care	1,290,438	32
33	General Administration	756,469	33
B. Capital Expense			
34	Ownership	205,647	34
C. Ancillary Expense			
35	Special Cost Centers	54,750	35
36	Provider Participation Fee	51,465	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,913,640	40
41	Income before Income Taxes (line 30 minus line 40)**	(62,453)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (62,453)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **GOOD SAMARITAN CARE CENTER**# **0011650**Report Period Beginning: **01/01/2001**

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	832	1,031	\$ 16,932	\$ 16.42	1
2					2
3	6,853	7,204	117,245	16.27	3
4	15,792	16,761	200,303	11.95	4
5	56,890	61,229	436,590	7.13	5
6					6
7					7
8	3,090	3,585	29,462	8.22	8
9	1,881	2,082	16,860	8.10	9
10	1,674	1,681	9,476	5.64	10
11	3,051	3,838	48,731	12.70	11
12					12
13	2,080	2,080	25,041	12.04	13
14					14
15	18,921	20,270	123,288	6.08	15
16					16
17	3,939	4,155	44,663	10.75	17
18	7,479	8,188	47,276	5.77	18
19	5,637	6,046	38,291	6.33	19
20	881	881	24,519	27.83	20
21					21
22	1,912	2,080	38,886	18.70	22
23	1,996	2,180	25,596	11.74	23
24	4,544	4,891	34,457	7.04	24
25					25
26					26
27					27
28					28
29					29
30					30
31	1,715	1,963	24,177	12.32	31
32	1,128	1,664	48,414	29.09	32
33	2,542	2,879	31,210	10.84	33
34	142,837	154,688	\$ 1,381,417 *	\$ 8.93	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	141	\$ 5,691	1-3	35
36	96	2,400	10-3	36
37	48	1,440	10-3	37
38				38
39				39
40				40
41				41
42				42
43				43
44	18	1,440	11-3	44
45	18	1,440	12-3	45
46		6,290	40-3	46
47	25	273	10-3	47
48	156	6,000	11-3	48
49	502	\$ 24,974		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	210	\$ 8,556	10-3	50
51	1,922	52,864	10-3	51
52	1,054	17,470	10-3	52
53	3,186	\$ 78,890		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Glenda Frazine	Executive Director	0%	\$ 38,886	Workers' Compensation Insurance	\$ 52,747	IDPH License Fee	\$
Barbara Waters	Administrator	0%	24,519	Unemployment Compensation Insurance		Advertising: Employee Recruitment	6,686
				FICA Taxes	101,542	Health Care Worker Background Check	950
				Employee Health Insurance	101,665	(Indicate # of checks performed 79)	
				Employee Meals		Dues	2,810
				Illinois Municipal Retirement Fund (IMRF)*		Employee Relations	6,221
				Employee Physicals	1,289	Advertising	12,533
				Hepatitis Inoculation	1,278	Licenses	244
				Unemployment Claims	9,000		
				Workers Comp Retro Adj.	4,000		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **GOOD SAMARITAN CARE CENTER**

STATE OF ILLINOIS

0011650

Report Period Beginning: **01/01/2001**

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Ending: **12/31/2001**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$2,525
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,900 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,465
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,881
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation. See Schedule V, Line 24 attachment.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.